PRIOR AUTHORIZATION REQUEST

Gender Affirming Care

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Gender Affirming Care – Gender Dysphoria/Incongruence (If checked, go to 2)

[] Other (If checked, no further questions)

2 Is this request for Initial or Continuation of therapy?
[] Initial (If checked, go to 6)

[] continuation (If checked, go to 3)

3 Has the patient been receiving medication samples for the requested medication? Yes No
[If yes, skip to question 6.]

If you have any questions, call: 1-888-258-8250

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4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	Has documentation been provided to confirm the diagnosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Is the patient's experience of gender affirming care marked and sustained as attested by the prescriber? [If no, no further questions.]	Yes	No
8	Does the prescriber attest that they have tried to identify and exclude other possible causes of apparent gender dysphoria/incongruence prior to the initiation of gender affirming care? [If no, no further questions.]	Yes	No
9	Does the prescriber attest that the patient does not have any contraindicating somatic or mental health conditions that would impair their ability to participate in informed consent? [Note: In the situation where a patient has a mental health condition that interferes with their capacity to give informed consent and understand the risks, benefits, and alternatives to gender affirming treatment, the prescriber should facilitate treatment of the underlying condition to support the individual's ability to provide informed consent.] [If no, no further questions.]	Yes	No
10	Does the prescriber attest that they have assessed the capacity of the patient to understand the effect of gender affirming treatment on reproduction and explore reproductive options with the patient prior to the initiation of treatment? [If no, no further questions.]	Yes	No
11	Does the prescriber attest that any mental health and somatic health conditions that could negatively impact the outcome of gender affirming care treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment? [If no, no further questions.]	Yes	No
12	Does the patient have the desire to make their body as congruent as possible and gender dysphoria/incongruence causes clinically significant distress or impairment	Yes	No

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	in social, occupational, or other important areas of functioning? [If no, no further questions.]		
13	Is the patient greater than or equal to 18 years of age? [If no, skip to question 15.]	Yes	No
14	Has documentation been provided to confirm medical necessity for Gender affirming Care from a Somatic Healthcare professional (SHP)/Primary Care Provider (PCP), or Mental Healthcare Professional (MHP), who has competencies in the assessment of transgender and gender diverse population? ACTION REQUIRED: Submit supporting documentation. [Note: Somatic Healthcare must possess one of the following degrees: MD, DO, NP, or PA. Mental healthcare professionals must possess one of the following: Ph.D., MD, DO, Ed.D., D.S.W., Psy.D, LCPC, LCSW-C, or NP.] [No further questions.]	Yes	No
15	Has documentation been provided to confirm medical necessity for Gender affirming Care from a multidisciplinary team that includes both a Somatic Healthcare Professional and a Mental Health Professional that have competencies in the assessment of transgender and gender diverse population? ACTION REQUIRED: Submit supporting documentation. [Note: Somatic Healthcare must possess one of the following degrees: MD, DO, NP, or PA. Mental healthcare professionals must possess one of the following: Ph.D., MD, DO, Ed.D., D.S.W., Psy.D, LCPC, LCSW-C, or NP.] [If no, no further questions.]	Yes	No
16	Does the patient have parenteral consent? [If no, no further questions.]	Yes	No
17	Does the patient demonstrate the emotional and cognitive maturity required to provide informed consent/assent for treatment as attested by the prescriber? [If no, no further questions.]	Yes	No
18	Has the patient reached Tanner stage 2 of puberty for pubertal suppression to be initiated?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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